EISENHOWER
IMAGING CENTER

Thyroid Ultrasound

Guest Name: _____ Date: _____

Medical Record Number: _____

Previous Thyroid Imaging ❑ Yes ❑ No

If yes, what type: _____

_____

Previous Thyroid Surgery ❑ Yes ❑ No

If yes, what type: _____

_____

Taking thyroid medication ❑ Yes ❑ No

If yes, how long: _____

Have you ever had your Thyroid radiated? ❑ Yes ❑ No

If yes, when: _____

Have you been diagnosed with ❑ Hypothyroid
Or
❑ Hyperthyroid

Current Symptoms: _____

_____

_____

_____

_____

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